ELECTRONIC DATA INTERCHANGE (EDI)

RELEASE NOTES

Patch IB*2*137

April 2002

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Introduction

The purpose of the EDI project is to provide VA facilities with a national solution to allow electronic billing of insurance companies. Currently there are a number of facilities that have local contracts to do electronic billing with various third party companies or directly with one or more insurance companies. Many of these solutions have required double entry of bills or IRM support to provide uploads of data. EDI will provide a common mechanism for electronic transmission of claims through the Austin Services Center, using ANSI ASC X12 EDI. The ASC X12 EDI standard provides a framework for health care billing information. Claims can be submitted to insurance companies and claim status can be returned to the submitter using EDI.

Ultimately this project will result in increased collections from third party carriers. Some fiscal intermediaries require EDI (Electronic Data Interchange). This project will allow sites to take advantage of these additional revenue sources. EDI is expected to make the billing process more efficient by allowing sites to put more emphasis on collections. The EDI functionality is part of the interim solution for Universal Billing.

Due to the size and complexity of this project, it is being released in four phases.

Phase I - Patch IB*2*136 was released to the field in October 2000. It provided MCCR and IRM employees with information necessary for the installation and implementation of Patch IB*2*51.

Phase II - Patch IB*2*51, Billing Enhancements for EDI, was released to the field on March 28, 2001. It included new billing edits, changes to both the UB-92 and HCFA 1500 printed forms (Output Formatter), and several changes to the Billing Screens. The edit changes implemented with IB*2*51 were required to bill according to the industry standards and to support this patch, IB*2*137.

Phase III – The third phase of the project, Patch IB*2*137, standardizes billing to meet industry billing requirements, the ANSI ASC X12 transaction code set requirements for electronic billing,

Phase IV – the fourth and final phase of the project, Patch IB*2*155, allows for Medicare non-reimbursable billing, in order to obtain a Medicare Remittance Advice (MRA).

Documentation

The software and Release Notes are available on the following OI Field Offices' Anonymous.Software Directories. Use the appropriate FTP capability to retrieve the files.

OI FIELD OFFICE	FTP ADDRESS	DIRECTORY
ALBANY	ftp.fo-albany.med.va.gov	anonymous.software
HINES	ftp.fo-hines.med.va.gov	anonymous.software
SALT LAKE	ftp.fo-slc.med.va.gov	anonymous.software
FIRST AVAILABLE SERVER	download.vista.med.va.gov	anonymous.software

FILE NAMES	DESCRIPTION
IB_2_137.KID	Software Patch
IB_2_137REL.PDF	Electronic Data Interchange (EDI) Release Notes

Additional documents, either in pdf or word format pertaining to the successful implementation of this patch can be found at the following website location: http://vaww.rev.lrn.va.gov/revenue.

Click on “Electronic Data Interchange” for these documents.

EDI Billing Patch 137 Technical Notes
EDI Billing Patch 137 User Guide
EDI Billing Patch 137 Answers to Frequently Asked Questions
EDI Billing Patch 137 Leaders Guide
EDI Billing Patch 137 PowerPoint Presentation
EDI Enrollment Guide

EDI Patch IB*2*137 System Set-up Course (Select the On-line Revenue Cycle Education and Support Site and proceed to the EDI Patch IB*2*137 Set-up Process).

Please ensure the Release Notes, User’s Guide, and other pertinent documents are distributed to the appropriate users.

Functional Description

EDI Transmission Flow and Transmission Statuses

Bills are created the same as they were before EDI patch IB*2.0*137.

When the bill is authorized, if it is a transmittable bill (see Appendix B - Transmission Rules), the bill is flagged as transmittable. Once flagged as transmittable, it cannot be printed until it has been confirmed as received in Austin at least once. This status is called READY FOR EXTRACT. No data has been extracted from the bill at this point; however, an entry has been made to track the transmission of the bill in the EDI TRANSMIT BILL file (#364).

NOTE: UNLESS THERE IS AT LEAST ONE MEMBER IN THE IB EDI MAIL GROUP, NO ACTUAL TRANSMISSION OF BILL DATA CAN OCCUR.

Most of the time, these READY FOR EXTRACT bills are held and batched later for transmission. The auto-transmit of bills (or auto-queue for multiple runs per day) and the auto-purge of returned messages are now part of the [IB MT NIGHT COMP] job which should be queued to run each day.

There is also an option to allow manual transmission of one, some or all READY for EXTRACT bills, [IBCE 837 MANUAL TRANSMIT]. At the time of authorization, if the bill is in immediate need for transmission, it can be batched by itself and sent immediately.

During the batch and extract step, if errors are found (missing or bad data detected), a bulletin is sent to the IB EDI Mail Group listing the reason for the error and the bill #(s) affected. Any bill where an error has been detected will remain in READY FOR EXTRACT status. These bills must be examined and the problem corrected so the bill will be included in the next batch of claims submitted. Possible corrective action might be to cancel/clone the bill, edit the bad data and re-authorize it or cancel the bill outright. If the problem is a system problem, no action may be required for the specific bill and it can just be left to be included with the next bill transmission extract job. A system problem would include things like bad data specific to an insurance company or bad data defined at the site level.

Batching of bills does not occur until they are transmitted.

Once the bills have been 'batched' and transmitted, they must wait for a confirmation of receipt from Austin. The Austin data queue sends this confirmation to the site for every batch of bills it successfully receives from the site. Prior to this receipt being received, the transmission status of the bills is PENDING AUSTIN RECEIPT. There has been no outside verification of the data at this point. This simply means the transmission reached the Austin data queues and should be on its way to the clearinghouse in a very short time period.

The site-level transmission parameter EDI/MRA ACTIVATED can be changed after a bill has been flagged for transmission, but before the bill has been placed in a batch. Just before being extracted for transmission, a bill's transmission status is checked again to see if it meets the

criteria of this parameter. If, as a result of this parameter change, once-transmittable bills in READY TO EXTRACT status can become non-transmittable. If this happens, these bills will NOT be extracted and will be frozen in READY TO EXTRACT status. They cannot be transmitted and cannot be printed. If this should occur, the only way to free them for printing is to use the EXTRACT STATUS MANAGEMENT [IBCE EXTRACT STATUS] option. This option allows you to cancel the bills or cancel/clone and authorize them so they are no longer flagged as transmittable and thus may be printed locally. This should happen very rarely. The report READY FOR EXTRACT STATUS REPORT [IBCE READY FOR EXTRACT REP] can be used to list bills in this frozen status.

The EXTRACT STATUS MANAGEMENT [IBCE EXTRACT STATUS] option can also be used to list all bills in a READY FOR EXTRACT status, if the need arises to see what bills have been flagged for transmission, but have not yet been extracted and transmitted.

The contents and status of a batch can be viewed using the BATCH STATUS DETAIL REPORT [IBCE BATCH STATUS DETAIL].

If a batch has been "lost" and must be tracked down, there are 2 EDI report options that contain information to assist in tracking down a missing batch.

- The PENDING BATCH TRANSMISSION STATUS REPORT option [IBCE QUERY PENDING BATCH] will display the mail message that contained the batch, and the first and last date/time the batch was sent.
- The EDI BATCHES WAITING AUSTIN RECEIPT AFTER 1 DAY option [IBCE BATCHES PENDING TOO LONG] lists all batches by batch type that have been in a PENDING AUSTIN RECEIPT status for more than 1 day. The report includes the "pending since" date and the mail message # that contains each batch.

Once the batches are accumulated in Austin, they are 'translated' or placed in a standard format that the clearinghouse can understand, and sent to the clearinghouse. If, during this step, Austin finds any format problems with the data sent, the site will be contacted, and the entire batch of bills will be rejected. Since this is a manual process at Austin, no electronic rejection will occur, but once the problem is corrected, the batch of bills must be resubmitted, the old batch will be discarded and a new batch # will be assigned to the batch.

Once the clearinghouse receives the batches, they are put through a set of pre-payer edits and either sent to the insurance company (if the edits are passed) or they produce error messages. In either case, a message is sent back to the site for each bill to either confirm that it has been received and/or to list the errors. The transmit status of the bill changes to ACCEPTED NON-PAYER once these messages are received from the clearinghouse. This status does not mean the bill was correct. It simply means the clearinghouse has acknowledged the bill's receipt.

If the payer does not have an electronic connection to the clearinghouse, its bills are printed and mailed by the clearinghouse to the payer. If this happens, or if the payer's electronic connection does not include reporting back to the clearinghouse electronically, there will be no further electronic correspondence regarding these bills. The transmit status of this bill will be set to CLOSED.

If the payer does have an electronic connection AND has the capability of returning status messages electronically through the clearinghouse, the site may receive status messages from the payer. On filing these messages, the transmission status is changed to ACCEPTED PAYER. This does not necessarily mean the bill was valid, just that the payer has received the document.

Other Transmission Statuses
(These are all considered "final statuses".)

- Cancelled – if the bill has been cancelled via the normal IB cancel bill options.
- Error Condition – if there has been a message received and reviewed that was flagged as a reject message for a bill. Some reject messages are concealed in non-reject status messages, so this status is not always attained automatically for rejected bills.
- Corrected/retransmitted –when a claim is resubmitted through the EDI status processing options in CLAIMS STATUS AWAITING [IBCE CLAIMS STATUS AWAITING]. The retransmission can be done either by transmitting another electronic bill (cancel/clone) or by the printing and mailing the bill to the payer by the site (resubmit by print action).
- Closed – when a bill has no further need for electronic status updates. This occurs automatically when a bill is detected as being printed at the clearinghouse, or when some of the options within the CLAIMS STATUS AWAITING [IBCE CLAIMS STATUS AWAITING] module are used to finalize the processing of the bill. For example, if COB processing of the bill occurs (sending the remaining balance to the next payer on the bill), the transmission status of the "old" bill will be set to CLOSED. Also, when status messages are reviewed and a final review action is entered, you have the choice of whether or not to close the transmit record.

Resubmission of Claims

- Batches of claims may be resubmitted using the option RESUBMIT A BATCH OF BILLS [IBCE RESUBMIT BILL BATCH]. This would be appropriate if the batch was lost in the transmission to Austin or if there was a data problem in the batch that could be programmatically corrected without the user editing the bills.
  - If a batch has been confirmed as being received in Austin, a new batch will be created with a new batch #. The old batch will reference the new batch.
  - When a batch has already been confirmed as received in Austin and the batch is resubmitted, the option exists to exclude specific bills from the resubmission. This would be appropriate if there are one or more bills in the batch with data that does not pass the Austin edits. The batch can be immediately resubmitted without the problem claims and the problem claims can be resubmitted at a later time when the problem has been fixed. Because this results in a batch that is partially resubmitted, a report is available to track any claims that were excluded from this partial resubmission. This is called the Bills Needing Resubmission Action report [IBCE EDI BATCHES INCOMPLETE]. Running this report at periodic intervals will insure that any bills excluded from resubmission do not get forgotten. Once a bill that was excluded from a batch resubmit has been resubmitted (electronically or by print) or has been cancelled, it will no longer appear on the report.
- An individual claim may be resubmitted using the option RESUBMIT A BILL [IBCE RESUBMIT BILL]. With this option, the bill will be placed in its own batch and will be removed from its original batch.

Transmission Parameters/Rules

How we determine if a bill should be transmitted or processed locally.

There is a site parameter that must be set to allow transmission of bills.

There is a specific group of rate types that allow for bill transmission. The site may NOT edit this data. The current rate types allowing transmission are:

- REIMBURSEABLE INSURANCE
- SHARING AGREEMENT
- CHAMPUS, CHAMPUS REIMBUSEABLE
- CHAMPVA, CHAMPVA REIMBURSABLE

There is a parameter on each insurance company that must be set to allow transmission of bills to the insurance company.

There is also a new transmission rules module that allows for the site to designate the bills that can be transmitted, within the set of bills that fall within the three parameters listed above. This designation is by form type (UB92/HCFA 1500) and/or UB-92 bill type (ex: 131, 121, etc) and/or insurance company. Each site may also opt to create its own hard-coded rules that must be passed for a bill to be considered transmittable. Refer to Appendix B - Transmission Rules for details on how transmission rules are defined and used.

Each bill now has a field to override the determination that it will be transmitted. This field can be found on Screen 8 when editing the bill and if it's-set to PRINT LOCAL, the bill is never transmitted, regardless of any other rules or how the parameter values are set.

Return Message Exceptions

All messages returned to the site from EDI processing are sent to the mail group G.MCR (for live transmissions) or G.MCT (for test transmissions) at the bill's site. The server option [IBCE MESSAGES SERVER] must be added as a remote member of these mail groups. The server option determines the message type and the message will be temporarily filed in the EDI MESSAGES file (364.2). This is done to quickly load the data for the entire message without a lot of processing.

Once a message is successfully filed in the temporary EDI MESSAGES file, the message is automatically tasked to update the IB files. Once the task is complete, the message is deleted from this temporary file.

Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file(s) for its message type, the message will remain in this file. When using the RETURN MESSAGE EXCEPTIONS option, if any messages are found in the file, they will be listed on the screen. You may also request a list of messages using the EDI Messages Not Yet Filed report [IBCE MSGS PENDING TOO LONG]. If messages are found in this file a full day after the last run of the auto-transmission of EDI bills, a bulletin is sent to alert members of the IB EDI mail group.

There are 2 statuses for messages in this file.

- Pending: the task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- Updating: the task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a check is made to see if it is currently running. If it is, the message will not be re-tasked to update. Any message may be viewed or printed.

There are 2 actions available to get these messages out of the file.

- File Message: This action re-executes the tasked job to update the database with the contents of the message. This action is not valid if the message selected is currently updating the database or is currently queued to update the database.
- Delete Message: This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. You must hold the IB SUPERVISOR security key to perform this action.

Claims Status Awaiting – Return Electronic Status Messages

The IB files that are updated by return electronic status messages are dependent on the message type.

- Austin confirmations of receipt automatically update the bill transmit records (File 364 – EDI TRANSMIT BILL) with the date and time the confirmation was received, as well as the bill transmit status. This type of message is processed automatically and requires no user intervention.
- Status messages from the clearinghouse or the payers (also called 277s after the X12 data set for return electronic status messages) are stored in the BILL STATUS MESSAGE file (#361. Refer to the Claims Status Awaiting section in EDI Billing Patch 137 User Guide for further details on processing these messages.

A report exists for management purposes to track the errors returned. This report is called the Electronic Error Report [IBCE ELECTRONIC ERROR REPORT] and is intended to identify the who, what, and where of errors in the electronic billing process.

Once a return message has been marked as reviewed, it is a candidate for deletion. There is a new site parameter (DAYS TO WAIT TO PURGE MSGS (#8.02) in the IB SITE PARAMETERS file (#350.9) that will allow the user to indicate a minimum # of days that a message must be in a final review status before it will be automatically purged from the file. This will happen automatically as part of the IB nightly job. If the site desires to print the messages before they are deleted, this parameter would be left blank and a manual purge option is available that will allow selection of a more specific set of reviewed messages and will allow those messages to be printed before being deleted. This option is Status Message Management [IBCEM STATUS MESSAGE] and can be found on the EDI Return Message Management menu [IBCE 837 EDI REPORTS] on the main EDI menu.

Provider ID

Refer to Appendix A: PROVIDER ID SET UP AND MAINTENANCE for a detailed description of the Provider ID maintenance options and parameters

A new security key IB PROVIDER EDIT is required to access the Provider ID maintenance options.

To enter Provider IDs not dependent on any insurance company, use Option 1 (PROVIDER SPECIFIC IDS) on the Provider ID maintenance screen. For Source of ID, choose option 1 (PROVIDER'S OWN DEFAULTS). Select a VA or NON-VA type provider. Add/edit/delete provider specific IDs for that provider and a provider type, form type and care type. Care unit is not used for these numbers as care units are only associated with insurance company IDs, not individual providers.

To enter individual Provider IDs for an insurance company without selecting each provider separately, there are 3 ways provided using Option 5 (INS CO BATCH ID ENTRY) on the Provider ID maintenance screen. Currently, only one selection using option 5 (Manual Entry) is available.

- For manual entry from VistA files: Select M (Manual Entry) for PROVIDER ID DATA SOURCE, a provider type, form type, care type and, if applicable, care unit. The system will then find providers and present them by provider name, provider SSN, or in the order they're found based on the following criteria.
- Any provider found in the PTF file (45/field 50) for admissions within the last two years.
- Any provider found in PCE (V PROVIDER file 9000010.06) associated with VISITS in the VISIT file (9000010) for visit dates within the last 2 years.
- **NOT YET AVAILABLE ** For auto entry from PHOEBE files: Select P (Entry from PHOEBE file) for PROVIDER ID DATA SOURCE. (Not currently operational)
- **NOT YET AVAILABLE ** For auto entry from non-PHOEBE files: Select O (Entry from Other file) for PROVIDER ID DATA SOURCE. (Not currently operational)

Bulletins/Alerts

All bulletins are sent to the IB EDI Mail Group.

EDI BATCHES WAITING AUSTIN RECEIPT MORE THAN 1 DAY: Sent if batches that should have received Austin confirmation are still waiting for the confirmation 1 day after they were transmitted.

EDI 837 TRANSMISSION ERRORS: Sent if, during an attempted transmission of bills to Austin, there is a problem with one or more bills that needs to be addressed. Any bill that is included in this bulletin is NOT transmitted.

EDI 837 SUBMISSION BATCH LIST: Sent each time a transmission of bills to Austin occurs to track the batches that were sent.

EDI RETURN MESSAGE ROUTER ERROR: Sent if an EDI message is received at the site from Austin with an invalid record type indicator.

EDI MESSAGE NOT FILED AFTER 1 DAY: Sent if there are EDI messages that have become 'stuck' in the initial message file and have not been filed in their permanent files (Status) after a full day has passed. Someone must look at the messages and determine why they did not completely file into their respective files and take appropriate remedial action.

EDI 837 BILL OR BATCH NOT RESUBMITTED: If a bill or batch is manually resubmitted and the task is queued, this is a bulletin to let someone know that an error occurred during the transmission and the batch/bill was not resubmitted successfully.

EDI BILLS NOT RESUBMITTED WITH THEIR BATCH: If a batch is resubmitted and the person doing the resubmission opts to exclude one or more bills from the resubmission, this bulletin alerts the mail group that the excluded bills must be manually resubmitted.

EDI MESSAGE DELETED: If an EDI message in the temporary file IB EDI MESSAGE (#364.1) is deleted without completion of the update of the appropriate IB files (Status), this bulletin is sent. It tells who deleted the message and when it was deleted and includes a copy of the entire message in case it was deleted in error.

PAYER ID RETURNED IS DIFFERENT THAN PAYER ID ON FILE: An EDI electronic ID number can be specified for an insurance company to enable the clearinghouse to route the claim to the correct payer electronically. In order to avoid having the sites load these for all insurance companies, the clearinghouse will attempt to calculate this for us, based on the insurance company address we provide them. When this number is returned to the site as part of the claim status messages, if it differs from the ID already stored on the site's insurance co file, this bulletin is sent to warn the user of the discrepancy.

Option/Functionality Change Highlights

Only the obvious changes to the IB package introduced by this patch are listed here. Refer to the EDI Billing Patch 137 Technical Notes for detailed changes to this patch.

Enter/Edit Billing Information IB EDIT BILLING INFO

- Refer to the section on billing screen changes for new/changed fields on screens 3, 6, 7 and 8.
- Edits for preventing the bill from crossing the fiscal or calendar year have been removed.
- Provider IDs (Screen 8) are required for rendering and attending providers.
- Non-VA providers are no longer entered as free text on Screen 8, but must be added to the new IB NON VA BILLING PROVIDER file (#355.93) using the new provider option provided with this patch.
- When a bill is authorized, the following fields may be automatically updated.
    - If the bill has more than one insurance company on it as payers and the other insurance is held by a person who is not the one holding the current insurance, the date of birth of the other insured (if it can be determined) is entered into the bill as an occurrence code. Occurrence codes A1/B1/C1 are used to designate the birth date of the primary/secondary/tertiary insured respectively.
    - If the bill is an inpatient bill and there is no 01 or 02 value code already on the bill, a value code 01 is added to the bill with a value equal to the highest unit charge found from the '101' revenue codes on the bill. This value code represents the semi-private room rate.
    - If the bill is an outpatient UB92 bill, and there is no admission source, the admission source is changed to 2 (CLINIC REFERRAL).
    - If the bill is an outpatient UB92 bill, and there is no discharge status, the discharge status is changed to 01 (DISCHARGED TO HOME OR SELF CARE)
- **Screen Changes**

    Screen 3
    - New field for transmit status. (display only)
    - New field for electronic ID # if defined for the current insurance co and the bill's form type. (display only)

    Screen 6
    - Adds co-insurance days field to display (for MEDICARE WNR only)
    - Removed the fiscal year totals from screen as they are no longer needed.

    Screen 7

- Modifications have been made so that when the user enters a manual charge with a procedure (not one created by reasonable charges), they now have the ability to make an association between that charge and a CPT code that already exists on the bill.

Screen 8 (both HCFA 1500 and UB-92 form type):
- New edit group 6 for FORCE TO PRINT
- New edit group 7 for access to provider ID maintenance

New Warnings

- When the bill's force to print field is anything other than NO.
- When 0-charge line items are found on a transmittable HCFA 1500 bill, these line items will not be transmitted.
- When 0-charge revenue codes are found on a transmittable UB92 bill, these revenue codes will not be transmitted.
- When any block 24K data is found on the line items of a transmittable, the block 24K data will not be transmitted.
- When there are more than 9 diagnoses on a UB92 bill, the bill will be printed locally and not transmitted.
- When there is no source of admission for an outpatient UB92 bill, the default of CLINIC REFERRAL (2) will be used.
- The provider credentials on screen 8 will automatically pull from either the NEW PERSON FILE (#200) or the IB NON VA BILLING PROVIDER FILE (#355.93). If the credentials are edited a warning will display letting the user know that edited credentials will only display if the bill is printed locally.

New Edits

- Provider IDs on a HCFA 1500 form are now required.
- MEDICARE HIC # must be in a valid MEDICARE format.
- Patient's first and last names must each begin with an alphabetic character.
- The first character of patient address or city cannot be a space.

Deleted Edits

- Bills can now cross fiscal and calendar years.
- Value codes 01 or 02 don't have to be entered on the bill for inpatient bills. If one of these is not found at authorization, a default will be automatically entered on the bill.

Implementation Guidelines

During the installation process, you will be asked to provide the coordinator for the IB EDI and IB EDI SUPERVISOR mail groups. The software is installed with the EDI parameters turned off.

It is extremely important for sites to follow the steps outlined in the Installation Guide section to activate electronic billing transmission.

Technical Notes

Refer to the EDI Billing Patch 137 Technical Notes for detailed documentation of the patch components.

System Resources

The software will provide IB with the capability to transmit bills electronically. The software interacts with Accounts Receivable as it does today. It will interface with FSC Austin via mailman messages and an outside trading partner, WebMD, via the facilities at the FSC. There will be an increase in network activity , specifically traffic between vista and FSC Austin for claim status messages, bulletins, alerts and other messages.

New Options

IBCE 837 EDI MENU
This menu contains the options needed to process and maintain EDI 837 bill submission functions.

IBCE 837 EDI REPORTS
This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and file for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

IBCE 837 MANUAL TRANSMIT
This job batches and transmits bills that are in authorized or Request MRA status for insurance companies flagged to transmit electronically via EDI. This job can be executed at any time to transmit bills awaiting extract.

IBCE BATCH STATUS DETAIL
This report allows selection by batch #, status, or date last sent for

batches of EDI data. It includes the batch transmission status, date of transmission and all bills included in the batch with each bill's individual transmission status.

IBCE BATCHES PENDING TOO LONG
This report lists all batches by batch type that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than 1 day. Report includes pending since date and mail message # the batch is contained in.

IBCE CLAIMS STATUS AWAITING
Used by bill staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to mark the message as reviewed or under review and document user comments.

IBCE EDI BATCHES INCOMPLETE
This report lists all batches that have been resubmitted, but not all bills were included. These are batches that have at least one bill still not resubmitted or canceled.

IBCE ELEC REPORT DISPOSITION
This option allows the site to determine which clearinghouse generated electronic canned reports are to be sent to the EDI mail group and which should be totally ignored when received at the site.

IBCE EDI VIEW/PRINT EXTRACT
This option will display the EDI extract data for a bill.

IBCE ELECTRONIC ERROR REPORT
This report provides a tool for billing personnel to identify the who, what, and where of errors in electronic billing process.

IBCE EXTRACT STATUS
This is a list manager screen that will display bills that are trapped in a ready for extract status due to the EDI/MRA parameter being turned off. From here, the valid actions are cancel a bill, cancel/clone/authorize a bill without user interaction, or print the report. If a bill is cancelled thru this option the REASON CANCELLED (field #19) of the BILL/CLAIMS (#399) file will automatically be stuffed with EDI/MRA TURNED OFF.

IBCE MESSAGE SCREEN TEXT
This option allows for the display of a list of words or phrases that if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

IBCE MESSAGES SERVER
This option controls the reading and storing of return messages generated as a result of the processing of Integrated Billing electronic transmissions with the Austin translator.

IBCE MSGS PENDING TOO LONG
This report allows you to select receipt, rejection or both message types and a minimum # of days these messages have been PENDING or UPDATING before they will be included on the report. The report will then list all messages in the file that meet this criteria.

IBCE PROVIDER MAINT
This is the screen from which all provider id maintenance can be performed.

IBCE PRVNVA FAC EDIT
This option allows for entering and editing of NON-VA facility information for billing.

IBCE QUERY PENDING BATCH
This report shows the current transmission status of a batch's mail message. It also includes the mail message number it was sent in along with the first and last date/times it was sent.

IBCE READY FOR EXTRACT REP
This report provides a list of claims held in a Ready for Extract status due to the EDI/MRA IB site parameter field being turned off.

IBCE RESUBMIT BILL
This option allows a user to resubmit any previously transmitted bill that has not been flagged as being in error. A new batch number is assigned to any bills resubmitted with this option. If a bill is resubmitted with this option, it will no longer be able to be resubmitted with its original batch if that batch is later resubmitted.

IBCE RESUBMIT BILL BATCH
This option allows a user to resubmit a batch of bills that has previously been transmitted. A new batch number is assigned to the bills resubmitted with this option if the status of the batch indicates it was ever received by Austin. Specific bills within the batch can be excluded from the resubmission if needed.

IBCE RETURN MSG PROCESSING
This option allows for the display of a list of return messages that have been received at the site, but have been left in the temporary STATUS MESSAGE file. This may have been because of a system error or the message may not

have been received in a readable format. This option provides the means to delete the message or to attempt to reapply it against the VistA database.

IBCE RULE MAINTENANCE
This option will allow for the adding of new electronic transmission rules and to modify existing ones.

IBCE TRANSMIT SELECTED BILLS
This option allows a user to transmit one or more transmittable claims that are waiting to be transmitted and are in a WAITING FOR EXTRACT status.

IBCE TXMT MGMNT REPORTS
This menu contains the options needed to produce reports for the 837 EDI module that deal with the status of the transmission of electronic billing data.

IBCE VIEW PENDING BILL
This option allows for the user to enter the ENTER/EDIT billing information screens in a view-only mode for a selected authorized bill whose transmission status is either WAITING AUSTIN CONFIRM or READY FOR EXTRACT.

IBCEM MESSAGES WITHOUT REVIEW
This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file (#361.3). The report can be run for a user-selected date range on date the message was received at the site and may be sorted by message text that caused the message to not need a review or by bill #.

IBCEM STATUS MESSAGE
This option contains the functionality to print/purge electronically returned status messages that have been in a final review status for a user selected number of days.

Changed Options

MCCR Site Parameter Display/Edit
Print Authorized Bills
Print Bill
Insurance Company Entry/Edit

New Files

#355.9 IB BILLING PRACTITIONER ID
New file that will contain one record for each unique billing provider id number that an individual provider (practitioner) is assigned by an insurance company or by a licensing or government entity.

#355.91 IB INSURANCE CO LEVEL BILLING PROV ID
New file that will contain one record for each provider id that an insurance company assigns to a facility for ALL billing providers at the facility.

#355.95 IB PROVIDER ID CARE UNIT
New file that will contain the data values (referred to as care units) to be used to match a provider on a claim to the correct provider id #.

#355.96 IB INS CO PROVIDER ID CARE UNIT
New file that will contain the 'list' of care units that an insurance company uses to assign provider id's.

#355.97 IB PROVIDER ID # TYPE
New file that will contain entries that will be used to classify or identify the valid kinds of provider ids that the V.A. will use.

#361 BILL STATUS MESSAGE
New file that will contain a record for each bill status message received electronically.

#361.1 EXPLANATION OF BENEFITS
New file that will contain a record for each bill EOB message received electronically.

#361.2 IB ELECTRONIC REPORT DISPOSITION
New file that will contain the list of electronic reports returned from the clearinghouse and the instructions on whether they should be ignored or e-mailed to the IB EDI mail group.

#361.3 IB MESSAGE SCREEN TEXT
New file that will contain the list of electronic reports returned from the clearinghouse and the instructions on whether they should be ignored or e-mailed to the IB EDI mail group.

#364 EDI TRANSMIT BILL
New file that will contain a record for each bill for each time it is included in a batch for EDI transmissions.

#364.1 EDI TRANSMISSION BATCH
New file that will contain a record for each 'batch' created for EDI transmission.

#364.2 EDI MESSAGES
New file that will be the repository of all messages that are sent electronically back to the site relating to EDI processing.

#364.3 IB MESSAGE ROUTER
New file that contains a list of the transactions that can be handled by the IB message server.

#364.4 IB EDI TRANSMISSION RULE
New file that contains the national and user-defined transmission rules to be applied to a bill to determine if it is eligible for transmission via national EDI.

Updated Files

#36 INSURANCE COMPANY
#350.8 IB ERROR
#350.9 IB SITE PARAMETERS
#353 BILL FORM TYPE
#355.3 GROUP INSURANCE PLAN
#364.5 IB DATA ELEMENT DEFINITION
#364.6 IB FORM SKELETON DEFINITION
#364.7 IB FORM FIELD CONTENT
#399 BILL/CLAIMS
#399.3 RATE TYPE

Input Templates

Changed:
IB EDIT MCCR PARM (File #350.9)
IB SCREEN3 (File #399)
IB SCREEN6 (File #399)
IB SCREEN7 (File #399)
IB SCREEN82 (File #399)
IB SCREEN8H (File #399)
IB STATUS File (#399)
IBEDIT INS CO1 (File #36)

List Templates

New:
IBCE ELEC REPORT DISP
Displays all reports returned electronically from the clearinghouse. Allows user to select those they do not want to receive.

IBCE EOB LIST
Displays existing EOB's for a selected bill, allows view/enter/edit and COB actions for both electronic and manually added EOB processing.

IBCE EXTR STATUS MANAGEMENT
Displays transmittable bills 'trapped' in READY TO EXTRACT status due to EDI and/or MRA being inactivated after the bills were authorized but before they were actually extracted for electronic transmission.

IBCE MESSAGE TEXT MAIN
Displays the existing message text defined for the site to 'screen' return messages from needing manual review.

IBCE PRVCARE UNIT MAINT
Displays care unit values for a selected insurance company

IBCE PRVFAC MAINT
Displays provider id numbers defined for the facility for the entire facility

IBCE PRVINS ID
Displays insurance company specific provider ids.

IBCE PRVINS ID FROM INS MAINT
Same as IBCE PRVINS ID with the insurance company pre-selected.

IBCE PRVINS PARAM DISPLAY
Displays insurance company parameters for provider id.

IBCE PRVMAINT
Displays provider id maintenance master menu

IBCE PRVNVA MAINT
Displays non VA provider demographic data for a selected non-VA provider.

IBCE PRVPRV MAINT
Displays the ids specific to a provider.

IBCE RULE BT RESTRICT
Displays transmission rule detail for a rule that restricts bill type

IBCE RULES
Displays a list of all transmission rules by rule type.

IBCEM 837 MESSAGE LIST
Displays a list of all electronically received billing messages from Austin that have not been properly filed in VistA

IBCEM BATCH BILL LIST
Displays a list of all bills assigned to a selected batch.

IBCEM CSA LIST
Displays a list of status messages that were returned electronically and were not marked as reviewed.

IBCEM CSA MSG
Displays detailed information for a selected claims status message, allows selection of various actions to review the message.

IBCEM EOB DETAIL
Displays EOB's on file that require review.

IBCEM EOB MANAGEMENT
Displays a list of those bills that can possibly be forwarded to the next sequential carrier for further payment (COB process) and/or those bills having received electronic EOB's that have not been flagged as having been fully reviewed.

IBCEM EOB REVIEW
Displays Comments made on an EOB through EOB management for a specific EOB entry.

IBCEM EOB VIEW EOB
Displays the full EOB detail for a pre-selected entry.

IBCEM VIEW EOB
Displays detail information for an EOB record.

IBJT EDI STATUS
Displays last EDI return message and the transmitted status for an electronic bill.

IBJT EDI STATUS ALONE
Same as IBJT EDI STATUS, but with display only (no protocol menu) of the last EDI return message and the transmitted status for an electronic bill.

Changed List Templates:
IBJT ACTIVE LIST
IBCNS INSURANCE COMPANY

Print Templates

Changed:
IBCE LOCAL DATA ELEMENTS
IBCE RULE DISPLAY
TRANSMISSION RULE (#364.4) FILE
IBCE RULE DISPLAY HEADER
IBCEM MESSAGE LIST
IBCEM MESSAGE LIST HDR

Protocols

New:
IBCE ELEC REPT MENU
IBCE ELEC RPT ADD/EDIT
IBCE EOB CHANGE BILL
IBCE EOB LIST
IBCE EOB VIEW
IBCE EXTR CANCEL
IBCE EXTR CLON/AUTH
IBCE EXTR MENU
IBCE EXTR PRINT
IBCE MANUAL EOB ADD
IBCE MANUAL EOB DELETE
IBCE MANUAL EOB EDIT
IBCE MESSAGE SCREEN TEXT EDIT
IBCE MESSAGE TEXT DISPLAY
IBCE PRVCARE ADD
IBCE PRVCARE EDIT
IBCE PRVCARE UNIT MAINT
IBCE PRVCARE UNIT MENU
IBCE PRVFAC EDIT
IBCE PRVFAC MAINT

IBCE PRVINS ADD
IBCE PRVINS CHG FORMAT
IBCE PRVINS CHG INS
IBCE PRVINS DELETE
IBCE PRVINS DISPLAY PARAMS
IBCE PRVINS EDIT
IBCE PRVINS FROM INS MAINT
IBCE PRVINS ID
IBCE PRVINS JUMP
IBCE PRVINS PARAM DISPLAY MENU
IBCE PRVINS PARAM EDIT
IBCE PRVMAINT
IBCE PRVMAINT ACTION
IBCE PRVNUM ADD
IBCE PRVNUM DELETE
IBCE PRVNUM EDIT
IBCE PRVNVA DEMOG
IBCE PRVNVA IDS
IBCE PRVNVA MAINT
IBCE PRVPRV MAINT
IBCE PRVSTATE LICENSE
IBCE RULE ACTIVE DATES EDIT
IBCE RULE ACTIVE ONLY
IBCE RULE ADD
IBCE RULE BILL TYPE EDIT
IBCE RULE BOTH ACTIVE AND INACTIVE
IBCE RULE BT ADD
IBCE RULE BT DELETE
IBCE RULE BT EDIT DATES
IBCE RULE BT RESTRICT MENU
IBCE RULE DISPLAY
IBCE RULE DISPLAY ALL
IBCE RULE INS OPT EDIT
IBCE RULE MENU
IBCE RULE MISC EDIT
IBCEM 837 MESSAGE MENU
IBCEM BATCH BILL MENU
IBCEM CLAIMS STATUS AWAITING
IBCEM CLONE BILL
IBCEM COB CANCEL
IBCEM COB CSA
IBCEM COB EDI
IBCEM COB EDIT BILL
IBCEM COB EOB
IBCEM COB EXIT
IBCEM COB MANAGEMENT

IBCEM COB PRINT REPORT
IBCEM COB RESUBMIT
IBCEM COB REVIEW STATUS
IBCEM COB TPJI
IBCEM COB V/P BILL
IBCEM COB VEOB MENU
IBCEM COPY SECOND/THIRD
IBCEM CSA CANCEL BILL
IBCEM CSA COB MANAGEMENT
IBCEM COB MANAGEMENT
IBCEM CSA COMMENTS
IBCEM CSA COPY/CANCEL BILL
IBCEM CSA EDI HISTORY
IBCEM CSA EDIT BILL
IBCEM CSA EOB CLAIM
IBCEM CSA EOB CLAIM ADJ
IBCEM CSA EOB GEN
IBCEM CSA EOB LINE ADJ
IBCEM CSA EOB LINK
IBCEM CSA EOB MEDICARE
IBCEM CSA EOB OUTPATIENT
IBCEM CSA EOB PAY
IBCEM CSA EOB REVIEW
IBCEM CSA MSG DETAIL
IBCEM CSA MSG MENU
IBCEM CSA MULTI SELECT REVIEW
IBCEM CSA PRINT BILL
IBCEM CSA PROCESS COB
IBCEM CSA REPORT
IBCEM CSA RESUBMIT BILL
IBCEM CSA RETRANSMIT BILL
IBCEM CSA REVIEW STATUS
IBCEM CSA TPJI
IBCEM CSA VIEW EOB
IBCEM DELETE MESSAGE
IBCEM DELETE STATUS MESSAGES
IBCEM FILE MESSAGE RECEIVED
IBCEM RESUBMIT BATCH
IBCEM SELECT BATCH BILL
IBCEM STATUS MSG MENU
IBCEM VIEW/PRINT STATUS MESSAGES
IBCEM VIEW/PRINT MESSAGE
IBCNSC PROVIDER ID PARAMETERS
IBJT EDI STATUS SCREEN
IBJT EDI STATUS MENU

Changed Protocols:
IBCE EXIT
IBCNSC INSURANCE CO
IBJT ACTIVE LIST SCREEN SKIP
IBJT BILL CHARGES MENU
IBJT BILL DX MENU
IBJT BILL PROCEDURES MENU
IBJT CLAIM SCREEN MENU
IBJT PT ELIGIBILITY MENU

Security Keys

New:
IB PROVIDER EDIT

Mail Groups

New:
IB EDI
IB EDI SUPERVISOR
MCT
MCR

Installation Guide

Refer to the National Patch Module Release of IB*2*137 for instructions on retrieving and installing this patch.

This patch must be installed by all Legacy sites.

This installation can take up to 4 or more hours to complete, depending on the size of your database for the files involved. Refer to Appendix C for a sample installation.

This patch should be installed after normal working hours. The IB MT NIGHT COMP job should not be running during installation.

The software will be installed with EDI turned off. In addition, the TRANSMIT ELECTRONICALLY field (#3.01) of the INSURANCE COMPANY FILE (#36) will be set to NO.

Refer to the 'FOR MCCR' section of the Post-Install for detailed instructions on setting parameters for activating electronic transmission functionality.
Post-Install There is one new global associated with this patch, ^IBM. This global will contain data for two new files, BILL STATUS MESSAGE (#361) and EXPLANATION OF BENEFITS (#361.1). Journaling for ^IBM is recommended.

For every active INSURANCE COMPANY file entry (#36), the post install will attempt to update the parameters for performing Provider ID (PERFORMING PROVIDER ID TYPE (#4.01), PERFORMING PROV ID SOURCE (#4.02), and the ELECTRONIC INSURANCE TYPE (#3.09)), based on the TYPE OF COVERAGE field (#.13) in the same file, if possible.

Following is how the parameters will be set.

If TYPE OF COVERAGE for the insurance company is defined as:

Medicare: ELECTRONIC INSURANCE TYPE = MEDICARE, PERFORMING PROVIDER ID TYPE = UPIN, PERFORMING PROV ID SOURCE = FACILITY (Note: UPIN default for facility = VAD000)

Medicaid: ELECTRONIC INSURANCE TYPE = MEDICAID

CHAMPVA: Medicare: ELECTRONIC INSURANCE TYPE = OTHER

Blue Cross: PERFORMING PROVIDER ID TYPE = BLUE CROSS, PERFORMING PROV ID SOURCE = INSURANCE CO, ELECTRONIC INSURANCE TYPE = OTHER

Blue Shield: PERFORMING PROVIDER ID TYPE ID = BLUE SHIELD, PERFORMING PROV ID SOURCE = INSURANCE CO, ELECTRONIC INSURANCE TYPE = OTHER

CHAMPUS: PERFORMING PROVIDER ID TYPE = CHAMPUS (NO PERFORMING PROV ID SOURCE), ELECTRONIC INSURANCE TYPE = OTHER

HMO: PERFORMING PROVIDER ID TYPE = COMMERCIAL, PERFORMING PROV ID SOURCE = INSURANCE CO, DEFAULT PERF ID IF MISSING? = ALTERNATE ID SOURCE, ELECTRONIC INSURANCE TYPE = HMO

Other than the above: PERFORMING PROVIDER ID TYPE = COMMERCIAL, PERFORMING PROV ID SOURCE = INSURANCE CO, DEFAULT PERF ID IF MISSING? = ALTERNATE ID SOURCE, ALTERNATIVE PROVIDER TYPE = FEDERAL TAX ID, ALTERNATE PERF PROV ID TYPE = FACILITY, ELECTRONIC INSURANCE TYPE = GROUP

The post-install will automatically update the ELECTRONIC PLAN TYPE FIELD (#.15) of the GROUP INSURANCE PLAN FILE (#355.3) based on the MAJOR CATEGORY of plan. If the Type of Insurance Coverage for the plan's insurance company is BLUE CROSS or BLUE SHIELD, this is a BC/BS plan type if the MAJOR CATEGORY of the plan is not one of the specific ones listed below.

MAJOR CATEGORY	**ELECTRONIC PLAN TYPE**
HMO	HMO
PPO	PPO
MEDICAIDE	MEDICAID
MEDICARE	MEDICARE A OR B
CHAMPUS	CHAMPUS
INDEMNITY	INDEMNITY
NONE OF ABOVE/NOT BCBS	COMMERCIAL

The ELECTRONIC TRANSMIT field in the RATE TYPE file (#399.3) is set to 1 (ALLOWED) for the following rate types: SHARING AGREEMENT, REIMBURSABLE INS., CHAMPVA, CHAMPVA REIMB.INS, CHAMPUS, and CHAMPUS REIMB. INS.

The data in the PROVIDER multiple is converted from free text to a pointer that allows both VA and NON-VA providers. For any non-VA provider found, an entry is added in the IB NON VA BILLING PROVIDER file (#355.93). Duplicate entries may occur here, since a match is checked for an existing name (less spaces and punctuation) and credentials. If both of these don't match, a new entry is added to the IB NON VA BILLING PROVIDER file. If duplicates are not acceptable, this file should be reviewed after the install, using FileMan to identify and delete the duplicates and re-point the entries, if necessary.

The following steps must be taken to set the site up correctly for EDI transmission.

ONCE INSTALLED, ALL TRANSMISSION AND INSURANCE PARAMETER SETTINGS SHOULD BE COORDINATED WITH YOUR MCCR COORDINATOR/BILLING STAFF.

FOR IRM:

1. After the install is complete, make sure the nightly compilation job for means test/autobiller [IB MT NIGHT COMP] is queued to run. The auto-transmit of bills (or auto-queue for multiple runs per day) and the auto-purge of returned messages are now part of this job.

2. Set up 2 mail groups, MCT and MCR, with the following parameters:
   MEMBERS - REMOTE: S.IBCE MESSAGES SERVER@<production domain>
   TYPE: PUBLIC
   ALLOW SELF ENROLLMENT: NO
   RESTRICTED: UNRESTRICTED

3. Two new domains must be set up on your system called Q-MCT.VA.GOV and Q-MCR.VA.GOV. These are standard domains to be used to route the bills via mailman to the Austin data queues. Make sure the RELAY DOMAIN = FOC-AUSTIN.VA.GOV, FLAGS = S.

4. Populate the IB EDI Mail Group with members who should receive EDI-related bulletins. NOTE: If there are no members in this mail group, EDI notifications and errors will be lost and transmission of bills will be prohibited. Also populate the IB EDI SUPERVISOR Mail Group with the names of the members who will receive copies of any unformatted EDI status reports ('RO' reports returned from the clearinghouse).

FOR MCCR:

1. For each insurance company that will be receiving the electronically transmitted bills, set the TRANSMITTED ELECTRONICALLY field (#3.01) in the INSURANCE COMPANY file (#36) to be either YES-TEST or YES-LIVE, depending on whether you wish to process in a test mode (bills will still print and should be mailed to insurance company) or in a live mode (bills are automatically sent electronically and cannot be printed until the confirmation of receipt message has been received from Austin). Use the Insurance Company Entry/Edit option [IBCN INSURANCE CO EDIT] to edit this field. If you choose to send test bills only, you may limit the # of bills sent per day if you update the insurance company's MAX NUMBER TEST BILLS PER DAY (#3.06) parameter. Initially turning on one insurance company at a time is advised.

2. Use option MCCR Site Parameter Enter/Edit [IB MCCR PARAMETER EDIT] to populate the IB SITE PARAMETERS file (#350.9) with the electronic billing parameters.
   - AUTO TRANSMIT BILL FREQUENCY (#8.03)
   - HOURS TO TRANSMIT BILLS (#8.06)
   - MAX # OF BILLS IN A BATCH (#8.04)
   - EDI/MRA ACTIVATED (#8.1)
   - ONLY 1 INS CO PER CLAIM BATCH (#8.07)

NOTE: If you set the HOURS TO TRANSMIT BILLS parameter, the nightly compilation job for means test/autobiller [IB MT NIGHT COMP] must run before the initial transmission will be queued to run.

Transmitted claims that have not been received in the Austin FSC queue by 5:00PM CST will not be forwarded to WebMD until the following day. When setting the HOURS TO TRANSMIT BILLS field, it is better to send bills multiple times during the day to avoid possible network delays and to ensure that claims will be received at the Austin FSC before 5:00PM CST.

3. Every insurance company must now be classified at 2 levels for EDI transmission. (These classification fields are auto-populated during the post install of the patch. Refer to section for INSTALLATION details.)
   - The first level is the ELECTRONIC INSURANCE TYPE field (#3.09) of the INSURANCE COMPANY file (#36). If this field is blank, GROUP is assumed. If the insurance company requires GROUP HEALTH PLAN to be checked in box 1 of the HCFA 1500, this field must be left blank or set to GROUP.
   - The next level is, for all plans for an insurance company, the ELECTRONIC PLAN TYPE field (#.15) of the GROUP INSURANCE PLAN file (#355.3). If this field is missing, COMMERCIAL is assumed. This field can be edited using the PLANS action of the INSURANCE COMPANY ENTER/EDIT IBCN INSURANCE CO EDIT option.
   - These 2 fields will be used to populate box 1 of the HCFA 1500 to have the correct box checked for the insurance when the bills are printed.

4. Make sure the Provider IDs are properly defined for each insurance company. Refer to Appendix A for details on insurance company specific ID definition details and to the section for INSTALLATION details on the auto-population of this field for all active insurance companies.

5. When billing prescription claims using a HCFA 1500 format, if there is no NDC code, the claim should be printed locally, not sent electronically.

Appendix A – Provider ID Set-up and Maintenance

Reasoning for Modifications for Provider IDs
The system of setting up and maintaining Provider IDs became an apparent need of the Integrated Billing system when electronic billing (EDI) was being developed. Since EDI involves codes describing specific ID types and numbers, we needed an efficient and convenient way of classifying and compiling all the numbers that could be assigned to a provider.

Definitions

PRACTITIONER	A provider of services. This differs from a provider in that this may only be defined as an individual, not as a facility.
PROVIDER ID TYPE	There are a variety of ID types that can be used in the billing system. Examples of these include EMC #, Commercial ID #, Blue Cross or Blue Shield ID #, MEDICARE ID #, UPIN, Network ID #, State License #, Tax ID #, CHAMPUS ID #. These are stored in table file (#355.97) called IB PROVIDER ID # TYPE.
FORM TYPE	The UB-92 or HCFA 1500 billing form on which services will be billed.
CARE TYPE	This describes the nature of the care being billed - inpatient, outpatient, or prescription.
CARE UNIT	Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown is insurance company specific.
NON-VA FACILITY	Any facility that provides services to a V.A. patient and subsequently bills the V.A. for these services.
NON-VA PROVIDER	Any individual provider who provides services to a V.A. patient and subsequently bills the V.A. for these services.

SOURCE OF ID

IDs can be specific to a facility, insurance company, provider; or a combination of these plus care unit. The source of ID is where in this hierarchy the specific ID comes from. Please see the following chart for further explanation.

Provider - licensing/gov't agency (1)	An ID specific to one provider and applies to all insurance companies. The system will retrieve the ID number from the NEW PERSON file (#200) or the IB BILLING PRACTITIONER ID file (#355.9). Example: An individual provider's UPIN or license number.
Facility ID (2)	An ID number that applies to every provider performing billable procedures at the facility. The system will retrieve the ID number from either the IB SITE PARAMETERS file (#350.9) (for the site's Federal Tax ID #) or the PROVIDER ID # TYPE file (#355.97). Example: site's federal tax ID or site's MEDICARE ID.
Insurance Co ID (3)	An ID number that applies to any provider on bills for that particular insurance company. The system will retrieve the ID number from the IB INSURANCE CO LEVEL BILLING PROV ID file (#355.91 - no specific care unit). Example: CHAMPUS ID.
Insurance Co/Provider ID (4)	An ID number for a specific provider, assigned by an insurance company. The system will retrieve the ID number from IB BILLING PRACTITIONER ID file (#355.9). Example: An individual provider's commercial ID as assigned by the insurance company.
Insurance Co/Care Unit ID (5)	The same as Insurance Co Ids, except the ID number applies to every provider of a specific care unit for the insurance company. The system will retrieve the ID number from the IB INSURANCE CO LEVEL BILLING PROV ID file (#355.96 - for the specific care unit). IDs defined here REQUIRE entry of care unit when an ID is entered.

Overview of Files

There are several new files added to support the new billing Provider ID functionality. Following are the new files and a brief description of their content.

#355.9 **IB BILLING PRACTITIONER ID file**: Contains the unique ID numbers assigned to an individual provider. This includes numbers assigned to the provider by a government or licensing agency, ID numbers assigned by an insurance company to an individual provider and ID numbers assigned by an insurance company to a combination of individual provider and care unit. The numbers stored in this file can be for either a VA-defined or NON-VA defined provider.

#355.91 **IB INSURANCE CO LEVEL BILLING PROV ID file**: Contains one record for each Provider ID that an insurance company assigns to a facility for ALL billing providers at the facility. Each record can be for an insurance company and any combination of the patient status, form type and care unit. There must be only one record for each combination. This file contains the ID numbers for numbers assigned by an insurance company to all providers and numbers assigned by insurance company, to all providers, one ID for each care unit.

#355.93 **IB NON VA BILLING PROVIDER file**: Contains a minimum amount of information about NON-VA individual providers or facilities being used as a source of care by the Integrated Billing system.

- For an individual provider, this file contains the provider name (required), provider type = 'INDIVIDUAL', credentials and specialty
- For a facility provider, this file contains the facility name (required), provider type = 'FACILITY', address (street, city, state and zip code), facility default ID number.

#355.95 **IB PROVIDER ID CARE UNIT file**: Contains the care unit values that can be used on individual bills to determine the correct ID based on care unit. Each entry is associated with one insurance company.

#355.96 **IB INS CO PROVIDER ID CARE UNIT file:** Contains the list of the care values that are valid for each particular insurance company. A finer breakdown is allowed within insurance company for specific form type, care type and Provider ID type. An example when the finer breakdown would be used is if the insurance company has assigned a different number for claims submitted on a UB-92 and a HCFA 1500 for a specific care unit value.

#355.97 **IB PROVIDER ID # TYPE file**: Contains the list of valid Provider ID types. This file also contains the facility default ID number, if appropriate, for Provider ID types.

New Provider ID Options

The new option, Provider ID Maintenance IBCE PROVIDER MAINT, resides on the Billing Supervisor Menu. It is used to perform all provider ID maintenance. Two groups of edits are displayed on the Provider ID Maintenance screen, Provider ID Edits and Non-VA Entity Edits. The IB PROVIDER EDIT security key is required to access this option.

Provider ID Edits

Provider Specific IDs

- Provider's Own IDs: Allows selection of either a NON-VA or VA provider. All IDs for the provider that have nothing to do with the facility or an insurance company are displayed.
- Provider IDs Furnished by an Insurance Company: Allows selection of either a NON-VA or VA provider and an insurance company. All IDs that are specifically assigned by that insurance company to the provider are displayed.

Provider IDs can be added/edited/deleted from these screens.

Insurance Company IDs

Allows selection of an insurance company and the content format of the ID list. The content formats are: If either of the 2 latter formats is selected, you may choose to limit the display to one provider or provider type for the insurance company.

Display Content	
Insurance Co Default IDs	Only those IDs assigned as defaults to the facility by the insurance company
Individual Provider IDs Furnished by the Ins Co	Only those IDs assigned to individual providers by the insurance company
All IDs Furnished by the Ins Co by Provider Type	All IDs assigned by the insurance company for one or all Provider ID types

Provider IDs for the entire insurance company, as well as for an individual provider for the insurance company can be added/edited/deleted from this screen. The following functions are also provided on this screen: Display Insurance Company Parameters, Change Insurance Company, Change Display Format, Care Unit Maintenance, and Move Around in List.

Facility IDs

Allows editing of site defaults for selected Provider ID types. Please see the MCCR Site Parameter Display/Edit section of this document for more information.

Care Unit Maintenance

Allows adding, editing, and deleting of the care unit record for insurance companies.

Insurance Company Batch ID Entry
Allows selection of manual entry by provider name or SSN, PHOEBE file input or custom file input of Provider IDs. If PHOEBE or other files are specified, the option exists to allow visual review and confirmation of each ID record before it is stored in VistA. Manual batch entry allows selection of a start point for the function. For "OTHER" file input, the user must define the type of file (delimited or fixed length) and where the IDs and SSN of the provider are located in the file (piece or start position and length).

Currently, only manual entry of Provider IDs is functional.

Non-VA Entity Edits

Non-VA Provider ID Information
Displays the name, credentials and specialty of the selected provider. Demographic data and Provider ID information can be added, edited, and deleted.

Non-VA Facility ID Information
Non-VA facility information can be added, edited, and deleted. This data includes name, address, and facility default Provider ID number.

Changed Options

Insurance Company Entry/Edit

A new section was added to the Insurance Company Editor screen (Insurance Company Entry/Edit option) that adds parameters used to define the Provider IDs. The following chart lists the Provider ID fields with a brief description.

Performing Provider ID	
PERFORMING PROVIDER ID TYPE	The type of Performing Provider ID # that the insurance company requires on bills received from the V.A. When the payer-specific Provider ID is extracted, this field is used to determine where to get the data. Choose from: BLUE CROSS ID BLUE SHIELD ID CHAMPUS ID COMMERCIAL ID FACILITY FED TAX ID # MEDICARE PART A MEDICARE PART B PROVIDER FED TAX ID # STATE LICENSE UPIN
PERFORMING PROV ID SOURCE	PROVIDER DEFAULT - insurance co needs an ID that has been assigned ONLY to an individual provider by other than the insurance co or the facility (State License #, UPIN, etc) FACILITY DEFAULT - insurance co needs an ID that has been assigned to the facility by other than the insurance co and will apply to all providers at the facility (Facility Federal Tax ID #) INSURANCE CO DEFAULT - the insurance co provides a single ID that applies to all providers at the facility. INS CO/PROV DEFAULT - the insurance co provides IDs that are specifically assigned to each provider at the facility. INS CO/CARE UNIT - insurance co provides IDs that are assigned based on the company's defined “care units” for care at the facility.
* DEFAULT PERF ID IF MISSING? (See further explanation below.)	This field is used to identify if there is an alternate ID that should be found if the performing provider's ID is not able to be determined at the insurance co's defined performing provider ID source level. There are two possible ways to search. This field defines whether the search should be for an alternate ID type or for a less-specific source for the same ID type. Choose from: 0 NO DEFAULT 1 DEFAULT TO MORE GENERAL 2 DEFAULT TO ALTERNATE ID TYPE

ALTERNATE PERF PROV ID TYPE	This is the alternate provider ID type to use to find the performing provider's ID when the default ID as defined by the performing provider ID type cannot be found. Choose from: BLUE CROSS ID BLUE SHIELD ID CHAMPUS ID COMMERCIAL ID FACILITY FED TAX ID # MEDICARE PART A MEDICARE PART B PROVIDER FED TAX ID # STATE LICENSE UPIN
ALTERNATE PERF PROV ID SOURCE	This is the alternate performing provider ID's source level. PROVIDER DEFAULT - insurance co needs an ID that has been assigned ONLY to an individual provider by other than the insurance co or the facility (i.e. State License #, UPIN, etc) FACILITY DEFAULT - insurance co needs an ID that has been assigned to the facility by other than the insurance co and will apply to all providers at the facility (i.e. Facility Federal Tax ID #) INSURANCE CO DEFAULT - the insurance co provides a single ID that applies to all providers at the facility. INSURANCE CO/PROV DEFAULT - the insurance co provides ids that are specifically assigned to each provider at the facility.
PERF PROV CARE UNIT PROMPT	This is the name of the specific care unit this insurance company needs on each claim to determine the correct performing provider ID #. For example, if specialty code is the care unit that the provider ID # is based on, you would enter SPECIALTY CODE here and, on each claim, enter the actual specialty code in the PROVIDER ID CARE UNIT field for the performing provider.

EMC ID	
EMC ID SOURCE	This is the source level where the insurance company expects the EMC ID to come from. Choose from: 3 INSURANCE CO DEFAULT - the insurance co provides a single ID that applies to all providers at the facility. 4 INS CO/PROV DEFAULT - the insurance co provides IDs that are specifically assigned to each provider at the facility. 5 INS CO/CARE UNIT - insurance co provides IDs that are assigned based on the company's defined 'care units' for care at the facility.
DEFAULT EMC ID IF MISSING?	This field indicates whether or not it is valid to search for an EMC ID at the next higher level than the default indicated, if the ID is not found using the default data. Choose from: 0 NO DEFAULT 1 DEFAULT TO MORE GENERAL
EMC CARE UNIT PROMPT	The name of the specific care unit this insurance company needs on each claim to determine the correct EMC ID # for the claim. For example, if specialty code is the care unit that the EMC ID # is based on, you would enter SPECIALTY CODE here and, on each claim, enter the actual specialty code in the EMC ID CARE UNIT field.
Network ID	
NETWORK ID SOURCE	This type of ID is not currently sent electronically. The source level the insurance company expects the network ID to come from. Choose from: 3 INSURANCE COMPANY DEFAULT - the insurance co provides a single ID that applies to all providers at the facility. 4 INSURANCE CO/PROVIDER - the insurance co provides IDs that are specifically assigned to each provider at the facility.
DEFAULT NETWORK ID IF MISSING?	This field indicates whether or not it is valid to search for a network ID at the next higher level than the default indicated if the ID is not found using the default data. Choose from: 0 NO DEFAULT 1 DEFAULT TO MORE GENERAL

* DEFAULT PERF ID IF MISSING?
The DEFAULT PERF ID IF MISSING field requires an entry of one of the following: NO DEFAULT, DEFAULT TO MORE GENERAL or DEFAULT TO ALTERNATE TYPE. If DEFAULT TO MORE GENERAL is selected, when trying to determine the correct ID for a bill, if the ID is not found at the specified source, the next higher or more general source is checked to see if a match can be found.

For example, assume the performing provider source for an insurance company is defined as INSURANCE CO/PROVIDER, and the performing provider ID type is COMMERCIAL, the performing provider ID for the insurance company (applies to all providers for the insurance company) exists and is 12345.

If the provider/insurance company PERFORMING PROVIDER ID were defined as ABCDE, ABCDE would be the ID number returned for the provider/ins company.

If the individual provider's PERFORMING PROVIDER ID is not defined for the insurance company:

If the DEFAULT PERF ID IF MISSING? field is set to NO DEFAULT, no Performing Provider ID will be returned for that provider and insurance company.

If the DEFAULT PERF ID IF MISSING? field is set to DEFAULT TO MORE GENERAL, the next more general Performing Provider ID (insurance company) 12345 will be returned for that provider and insurance company.

If the DEFAULT PERF ID IF MISSING? field is set to DEFAULT TO ALTERNATE TYPE, the ID found at the alternate ID source and for the alternate ID provider type (if any) will be returned.

MCCR Site Parameter Display/Edit

A new group of parameters, FACILITY LEVEL DEFAULT IDs (Edit Group 14), has been added under the IB PARAMETERS section of the MCCR Site Parameters screen (MCCR Site Parameter Display/Edit option). All facility default provider IDs can be edited from this screen. The FACILITY FED TAX ID cannot be edited here. Following are the IDs that can be edited using this option. These numbers represent the ID for all providers for the ID type at the facility if no number exists for the specific provider/insurance company or insurance company/care unit combination.

- BLUE CROSS ID
- BLUE SHIELD ID
- COMMERCIAL ID
- EMC ID
- MEDICARE PART A
- MEDICARE PART B
- NETWORK ID (not currently sent electronically)

New Functions for Provider ID Maintenance

- Entry/edit of individual Provider IDs via List Manager screens. All current IDs for the selected provider are displayed. New ones may be entered, and old ones may be deleted or modified.
- Entry/edit of new Provider ID defaults for insurance companies from the Insurance Company Editor screen (Insurance Company Entry/Edit option).
- Entry/edit of new Provider ID defaults for the site from the IB PARAMETERS section of the MCCR Site Parameters screen (MCCR Site Parameter Display/Edit option)
- The post-init will attempt to set up ID provider type and source defaults for active insurance companies, based on the TYPE OF COVERAGE defined for them. Refer to the INSTALLATION section for details on these defaults.
- A data entry option to initially enter IDs into the system. This would include selection of an insurance company where insurance company ID data can be entered and an action to allow a user to select the type or types of IDs this insurance company requires for its individual providers. The system would then prompt the user for provider name and just those ID type(s) requested.

Site Setup Considerations

Insurance Company Setup

For each insurance company, the site will need to determine and enter insurance company parameters for Provider ID determination.

- The Provider ID type to be used for the performing provider's ID.
  - The default source where the performing Provider ID will be found.
  - If care unit is required for the ID determination.
  - What the "prompt" for care unit will be when provider ID is to be entered (if left null, CARE UNIT will be used).
  - If the ID should only be found at the default source or, if no ID found there, if a more general search or an alternate ID will be allowed.
- The EMC ID source where the EMC ID will be found.
  - If the ID should only be found at the default source or, if no ID found there, if a more general search will be allowed (if the insurance company requires an EMC ID).
  - If care unit is required for the ID determination, what the prompt for care unit will be when provider ID is to be entered (if left null, CARE UNIT will be used).
  - Sources 3, 4, or 5 (INSURANCE COMPANY DEFAULT, INSURANCE CO/PROVIDER or INSURANCE CO/CARE UNIT) are the only valid sources for this ID. (See the chart in the Insurance Company Entry/Edit section for a description of these sources.)

- The NETWORK ID source where the NETWORK ID will be found. (not currently sent electronically)

- If the ID should only be found at the default source or, if no ID found there, if a more general search will be allowed (if the insurance company requires a NETWORK ID).
- Sources 3 or 4 (INSURANCE COMPANY DEFAULT or INSURANCE CO/PROVIDER) are the only valid sources for the NETWORK ID. (See the chart in the Insurance Company Entry/Edit section for a description of these sources.)

For each insurance company, the site must determine and enter Provider IDs specific to the insurance company, the insurance company and provider combination, or the insurance company and care unit combinations. Note: If care unit is required for any insurance company's Provider ID, the care unit values as defined by the insurance company must be entered into the care unit file along with the Provider ID type, care type, and form type that the care unit applies to.

Facility ID Setup

Each ID that can be defined at the facility source must be entered into the Provider ID type file, using the MCCR Site Parameter Display/Edit option.

Provider Default Setup

Provider-specific IDs must be added to the Provider ID file as they are received. This data may come from PHOEBE files, be manually entered, or received as Excel or other delimited ASCII files. Currently, only manual entry of Provider IDs is functional.

Enter/Edit Billing Screen Changes

SCREEN 6:

A new prompt has been added in EDIT GROUP 1 for co-insurance days for inpatient UB92 bills.

SCREEN7

- Modifications have been so that when a user enters a manual charge with a procedure (not one created by reasonable charges), they now have the ability to make an association between that charge and a CPT code that already exists on the bill.

SCREEN 8:

- When a user enters a provider name on Screen 8 of the billing screens, the appropriate ID numbers, specialty and credentials will automatically be pulled from the appropriate VistA source files. If the credentials are edited a warning will display letting the user know that edited credentials will only display if the bill is printed locally.
- Care unit prompts have been added for providers, to determine the correct ID for the performing provider and insurance company.
- Non-VA providers can be added to the NON-VA PROVIDER file.
- By entering /ID at any of the Provider ID prompts (primary/secondary/ tertiary), the system will attempt to retrieve the ID number that matches the conditions of the insurance company and site parameters. This can be used if an ID was manually entered in error, and the system calculated ID is needed instead.

- A new edit group 7 appears on this screen that will link into the Provider ID maintenance options. The first part allows the automatic population of IDs calculated from the Provider ID parameters for all providers on the bill. Then, if the user holds the IB PROVIDER EDIT key, access is provided to the Provider ID maintenance functions.

Appendix B – Transmission Rules

Transmission rules are used to define the rules for which bills should or should not be transmitted electronically a site. The option used to define transmission rules is Transmission Rule Maintenance [IBCE RULE MAINTENANCE].

There are 4 types of rules:

- 0 - LIMIT BY FORM TYPE (UB-92 or HCFA 1500): This type of rule is used to limit the transmission of PROFESSIONAL (HCFA-1500) or INSTITUTIONAL (UB-92) form types. If you pick one form type, no bills of the other form type will be transmitted for:
  - The insurance companies that were selected to be included OR
  - All insurance companies except those entered on the excluded list OR
  - Any insurance company if all insurance companies were selected.

- 1 - LIMIT BY SOME BILL TYPES: This type of rule is used to limit the transmission of bills with the specified UB-92 equivalent of bill type (111,131,etc - Location Of Care, Bill Classification, Timeframe Of Bill). This rule type can be used to restrict transmissions of both HCFA 1500 and UB-92 bills to specific bil types or to allow all bill types except those specified (these are entered preceded by a dash). A 'wild card' character of X can be used to indicate that any character in that position is included (i.e.: 11X will allow 111,112,113,etc). The rule will not allow transmission of bills unless they match the allowed bill types and do not match any of the excluded bill types for:
  - The insurance companies that were selected to be included OR
  - The insurance companies not entered on the excluded list OR
  - Any insurance company if all insurance companies were selected.

- 2 - MRA REQUEST RESTRICTIONS (reserved for future processing of MRA request claims)

- 9 - LOCALLY DEFINED: These rules can execute user-defined rules (coded in M). IRM must write the code and insert it into the rule's code field. It must return a truth-value of 1 to indicate the rule has been passed and the bill should be transmitted electronically. This rule type applies to all bills. When the code is executed, the following variables will be defined:
  - IBIFN: the ien of the bill being evaluated (pointer to File 399)
  - IBDA: the ien of the rule (pointer to File 364.4)
  - IB(.03): rule's transmission type value (internal)
  - IB(.05): rule's form type value (internal)
  - IB(.07): rule's insurance company option value (internal)

The transmission rules are structured to enable a site to designate that a bill must meet certain criteria before the rule is applied. Note that MRA transmission type, while able to be selected, will not be functional until the request for MRA functionality is released in the future. If a rule does not apply to a bill, the bill by default passes the rule. The criteria that can be defined for each rule type are:

For rule type 0: Transmission Type: EDI, MRA or both
All/Include/Exclude Insurance Companies
For rule type 1: Transmission Type: EDI, MRA or both
Form Type: UB-92, HCFA 1500 or both
All/Include/Exclude Insurance Companies
For rule type 2: Form Type: UB-92, HCFA 1500 or both
All/Include/Exclude Insurance Companies
For rule type 9: Transmission Type: EDI, MRA or both
Form Type: UB-92, HCFA 1500 or both
All/Include/Exclude Insurance Companies

The following text appears when you first select the rule maintenance option: "WARNING - MAKING CHANGES TO THE TRANSMISSION RULES USING THIS OPTION CAN SERIOUSLY AFFECT THE SITE'S ABILITY TO BILL. BE EXTREMELY CAUTIOUS WHEN USING THIS OPTION." This is shown because conflicting rules can paralyze a site's ability to transmit. Whomever enters new rules must have a thorough understanding of the existing rules and, although the system does some conflict checking, must make sure the rule(s) they are adding do not cause a conflict with other rules. This kind of conflict can cause all bills to fail the rules and the result will be no electronic bill transmissions occurring at the site.

Appendix C – Sample Installation

```
Load a Distribution
Enter a Host File: IB_2_137.KID
```

Select Kernel Installation & Distribution System Option: INstallation

1 Load a Distribution
2 Verify Checksums in Transport Global
3 Print Transport Global
4 Compare Transport Global to Current System
5 Backup a Transport Global
6 Install Package(s)
Restart Install of Package(s)
Unload a Distribution

Select Installation Option: 6 Install Package(s)
Select INSTALL NAME: IB*2.0*137 Loaded from Distribution 4/11/02@08:03:16
=> IB*2*137 ELECTRONIC BILLING (EDI) ;Created on Apr 10, 2002@15:11:07

This Distribution was loaded on Apr 11, 2002@08:03:16 with header of
IB*2*137 ELECTRONIC BILLING (EDI) ;Created on Apr 10, 2002@15:11:07
It consisted of the following Install(s):
IB*2.0*137
Checking Install for Package IB*2.0*137
Will first run the Environment Check Routine, IBY137EN

Install Questions for IB*2.0*137

Incoming Files:

36 INSURANCE COMPANY (Partial Definition)
Note: You already have the 'INSURANCE COMPANY' File.

350.8 IB ERROR (including data)
Note: You already have the 'IB ERROR' File.
I will OVERWRITE your data with mine.

350.9 IB SITE PARAMETERS (Partial Definition)
Note: You already have the 'IB SITE PARAMETERS' File.

353 BILL FORM TYPE (including data)
Note: You already have the 'BILL FORM TYPE' File.
I will OVERWRITE your data with mine.

355.3 GROUP INSURANCE PLAN (Partial Definition)
Note: You already have the 'GROUP INSURANCE PLAN' File.

355.9 IB BILLING PRACTITIONER ID

355.91 IB INSURANCE CO LEVEL BILLING PROV ID

355.93 IB NON VA BILLING PROVIDER (Partial Definition)
Note: You already have the 'IB NON VA BILLING PROVIDER' File.

355.95 IB PROVIDER ID CARE UNIT

355.96 IB INS CO PROVIDER ID CARE UNIT

355.97 IB PROVIDER ID # TYPE (including data)

361 BILL STATUS MESSAGE

361.1 EXPLANATION OF BENEFITS

361.2 IB ELECTRONIC REPORT DISPOSITION (including data)

361.3 IB MESSAGE SCREEN TEXT (including data)

362.4 IB BILL/CLAIMS PRESCRIPTION REFILL (Partial Definition)
Note: You already have the 'IB BILL/CLAIMS PRESCRIPTION REFILL' File.

364 EDI TRANSMIT BILL

364.1 EDI TRANSMISSION BATCH

364.2 EDI MESSAGES

364.3 IB MESSAGE ROUTER (including data)

364.4 IB EDI TRANSMISSION RULE

364.5 IB DATA ELEMENT DEFINITION (including data)
Note: You already have the 'IB DATA ELEMENT DEFINITION' File.
I will OVERWRITE your data with mine.

364.6 IB FORM SKELETON DEFINITION (including data)
Note: You already have the 'IB FORM SKELETON DEFINITION' File.
I will OVERWRITE your data with mine.

364.7 IB FORM FIELD CONTENT (including data)
Note: You already have the 'IB FORM FIELD CONTENT' File.
I will OVERWRITE your data with mine.

399 BILL/CLAIMS (Partial Definition)
Note: You already have the 'BILL/CLAIMS' File.

399.3 RATE TYPE (Partial Definition)
Note: You already have the 'RATE TYPE' File.

Incoming Mail Groups:

Enter the Coordinator for Mail Group 'IB EDI':

Enter the Coordinator for Mail Group 'IB EDI SUPERVISOR':

Want KIDS to Rebuild Menu Trees Upon Completion of Install? YES// NO

Want KIDS to INHIBIT LOGONs during the install? YES// NO

Want to DISABLE Scheduled Options, Menu Options, and Protocols? YES//

Enter options you wish to mark as 'Out Of Order': IB*

Enter options you wish to mark as 'Out Of Order':

Enter protocols you wish to mark as 'Out Of Order': IB*

Enter protocols you wish to mark as 'Out Of Order':

Delay Install (Minutes): (0-60): 0//

Enter the Device you want to print the Install messages.
You can queue the install by enter a 'Q' at the device prompt.
Enter a '^' to abort the install.

DEVICE: HOME// Decnet

Install Started for IB*2.0*137 :
Apr 11, 2002@08:07:14

Build Distribution Date: Apr 10, 2002

Installing Routines:
Apr 11, 2002@08:07:25

Running Pre-Install Routine: ^IBY137PR
Pre-Installation Updates

Delete xrefs and output formatter data that will be updated during install
>> ^DD(399,9) cross reference #2 deleted.
>> ^DD(399,151) cross reference #3 deleted.
>> ^DD(399,201) cross reference #1 deleted.
>> ^DD(399,210) cross reference #1 deleted.
>> ^DD(399.042,.04) cross reference #1 deleted.
>> All ^DD(399,6) cross references deleted.

Pre-install complete

Installing Data Dictionaries:
Apr 11, 2002@08:10:05

Installing Data:

Apr 11, 2002@08:14:11

Installing PACKAGE COMPONENTS:

Installing SECURITY KEY

```
Installing PRINT TEMPLATE

 Installing INPUT TEMPLATE


Installing MAIL GROUP

Installing PROTOCOL
  Located in the IB (INTEGRATED BILLING) namespace.
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 Installing LIST TEMPLATE

Installing OPTION
               Apr 11, 2002@08:14:46

Running Post-Install Routine: ^IBY137PO

Converting provider free text data to pointers in PROVIDER multiple of BILL/CLAIMS file

Step complete.

Updating RATE TYPE file with electronic billable flag

Step complete.

Updating INSURANCE file with EDI inactive status
```

Step complete.

Adding QUEUE names and EDI default data to PARAMETERS FILE

Step complete.

Updating insurance co electronic ins type and default prov ID parameters

Step complete.

Adding ELECTRONIC PLAN TYPE for each plan

Step complete.

Executing the new NDC format's cross reference - file 362.4

Step complete.

Post install complete.

Updating Routine file...

The following Routines were created during this install:
IBXX
IBXX1
IBXX10
IBXX11
IBXX12
IBXX13
IBXX14
IBXX15
IBXX16
IBXX17
IBXX18
IBXX19
IBXX2
IBXX20
IBXX21
IBXX22
IBXX23
IBXX24
IBXX25
IBXX26
IBXX3
IBXX4
IBXX5

IBXX6
IBXX7
IBXX8
IBXX9
IBXST
IBXST1
IBXST2
IBXST3
IBXST4
IBXST5
IBXST6
IBXST7
IBXST8
IBXPAR
IBXPAR1
IBXPAR2
IBXSC3
IBXSC31
IBXSC310
IBXSC311
IBXSC32
IBXSC33
IBXSC34
IBXSC35
IBXSC36
IBXSC37
IBXSC38
IBXSC39
IBXSC6
IBXSC61
IBXSC610
IBXSC611
IBXSC612
IBXSC613
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IBXSC62
IBXSC63
IBXSC64
IBXSC65
IBXSC66
IBXSC67
IBXSC68
IBXSC69
IBXSC7

IBXSC71
IBXSC710
IBXSC711
IBXSC712
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IBXSC714
IBXSC715
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IBXSC718
IBXSC719
IBXSC72
IBXSC720
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IBXSC722
IBXSC723
IBXSC73
IBXSC74
IBXSC75
IBXSC76
IBXSC77
IBXSC78
IBXSC79
IBXSC8H
IBXSC8H1
IBXSC8H2
IBXSC8H3
IBXSC8H4
IBXSC8H5
IBXSC8H6
IBXSC8H7
IBXSC8H8
IBXSC8H9
IBXSC82
IBXSC821
IBXSC822
IBXSC823
IBXSC824
IBXSC825
IBXSC826
IBXSC827
IBXSC828

Updating KIDS files...

IB*2.0*137 Installed.

Apr 11, 2002@08:15:02
Install Message sent

Install Completed